

The Importance of Accuracy and Care in Suicide Discourse: A Reply to Nock et al.

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We read with interest the commentaries on our article “What Distinguishes Suicide Attempters From Suicide Ideators? A Meta-Analysis of Potential Factors” (2016). While two offered positive sentiments and useful elaborations, we focus here on the commentary by Nock, Kessler, and Franklin (2016), which was decidedly negative. Nock et al. contains three main points. The second point is a thoughtful and substantive address of the inclusion criteria and limits of our meta-analysis. We are happy to reply to it, even if we do not fully agree. In contrast, Nock and colleagues’ first point (which broadly questions the novelty of our ideas and credit given to past work) and third point (which suggests our article fails to appreciate the difference between correlates and risk factors) are plainly and disconcertingly inaccurate. These inaccuracies distort the content of our work, magnify areas of real and perceived disagreement, and hinder substantive discourse. Our reply (a) refutes and corrects these inaccuracies, (b) reaffirms the critical need to distinguish attempters from idea-

tors, and (c) describes a framework for resolving this knowledge gap.

Key words: attempt, ideation, meta-analysis, prediction, review, risk factors, suicidal, suicide. [*Clin Psychol Sci Prac*, 2016]

We appreciate that three commentaries were obtained on our meta-analysis of factors that distinguish suicide attempters from suicide ideators. Two offered positive sentiments along with useful elaborations and suggestions, whereas a third by Nock, Kessler, and Franklin (2016) was decidedly negative. We were asked to reply to Nock et al. and are grateful for the opportunity to do so.

POINT 1: NOVELTY AND CREDITING PAST WORK

Nock and colleagues’ first point is that the focus of our work—the need to differentiate suicide attempters from suicide ideators—is not novel, timely, or a “critical frontier.” Instead, Nock et al. (2016, p. 3) state: “Research on the prediction of suicide attempts among people with suicide ideation has progressed well beyond” what we describe. Nock et al. include a supplement listing dozens of articles that address differences between attempters and ideators, ostensibly to suggest we understate the field’s knowledge of this topic. However, we think Nock et al. miss the point. What matters is not the number of studies to address the issue, but what we have learned from them. And we have not learned much. For example, Dr. Nock’s own summary of variables examined in the World Health Organization (WHO) studies notes that they explain 62% of the variance in suicide ideation, but “only 7.1% of the variance predicting suicide attempts

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among ideators” (Glenn & Nock, 2014, p. S177). In short, research has revealed numerous strong predictors of ideation, but nothing that strongly differentiates attempters from ideators. This is the point we emphasize in our meta-analysis and elsewhere. The need to distinguish attempters from ideators is indeed a critical frontier (Klonsky & May, 2014).

Moreover, based on his recent work, Dr. Nock appears to agree with and echo our perspective. A recent article by him (Glenn & Nock, 2014) published just a few months after our critical frontier article includes a section called “Breakthroughs Needed.” The first breakthrough addresses the field’s limited ability to “differentiate suicide attempters from suicide ideators,” and concludes “much more progress is needed in this direction” (p. S177). What we describe as a critical frontier, Dr. Nock describes as a needed breakthrough. It is hard to see the disagreement.

A related issue is that Nock et al. view the “ideation-to-action framework” as redundant with the findings from studies on their supplemental list. This is a gross oversimplification. While the Kessler, Borges, and Walters (1999) WHO, and other studies demonstrate the difficulty in differentiating attempters from ideators, they provide no answers. The ideation-to-action framework is intended to move the field forward, both in the research domain and in domains of risk assessment, theory, treatment, and prevention. The framework stipulates that (a) the development of suicidal ideation and (b) the progression from ideation to suicide attempts should be viewed as distinct processes with distinct explanations and predictors (Klonsky & May, 2014). One implication is that research must seek to identify new variables, beyond the “usual suspects” examined by WHO, Kessler et al., and others, that can better explain the transition from ideation to attempt. For example, Thomas Joiner suggests the capacity to attempt suicide facilitates the transition from ideation to attempts, and recent work guided by the ideation-to-action framework has supported and expanded this concept (Klonsky & May, 2015). Additionally, because the studies on the Nock et al. (2016) supplemental list constitute only a small subset of the thousands of studies on suicide correlates and predictors, they actually reinforce the need for the framework to guide future work. No longer should we conduct studies that

methodologically confound attempts and ideation. No longer should the studies on Nock and colleagues’ list be the exception rather than the rule.

Additionally, the ideation-to-action framework goes beyond the studies listed by Nock et al. because of its implications for theory and practice. These implications include the following: (a) risk factors should no longer comprise a single list but should be categorized according to whether they predict ideation, progression from ideation to attempts, or both; (b) theories of suicide should follow the example of Thomas Joiner’s interpersonal-psychological theory and provide separate explanations for the development of ideation and the progression from ideation to action (e.g., Klonsky & May, 2015); and (c) treatment and prevention programs should be clear about which intervention targets and mechanisms of change address ideation and which impede progression from ideation to attempts.

Finally, Nock et al. suggest we do not appreciate or acknowledge earlier work on this topic. This is perhaps their most careless point. They first single out a study by Kessler et al. (1999) that we ostensibly ignore, and emphasize that the study was published “over 15 years ago” (p. 1). In actuality, our article (Klonsky & May, 2014, pp. 1–2) from which Nock quotes the phrase “critical frontier” not only cites Kessler et al. (1999) but devotes almost a full paragraph to it, culminating with a direct quote:

This pattern led Kessler et al. (p. 617) to conclude: “All significant risk factors . . . were more strongly related to ideation than to progression from ideation to a plan or an attempt.”

Nock et al. also describe additional epidemiological studies that replicate Kessler et al. and that we supposedly ignore, including “nationally representative studies of >100,000 respondents from 21 different countries” (p. 1). However, these too we address explicitly (Klonsky & May, 2014, p. 2):

Notably, this general pattern reported by Kessler et al. was subsequently found in other large-scale studies . . . including an international epidemiological

study examining suicidality across 21 countries (Nock, Borges, & Ono, 2012), and an epidemiological study of adolescents (Nock et al., (2013).

In short, it is plainly inaccurate to suggest we do not credit these studies.

POINT 2: OMITTING WHO STUDIES FROM OUR META-ANALYSIS

Nock et al. disagree with our rationale to exclude WHO and other epidemiological studies from our meta-analysis and to instead address WHO narratively. We agree that these studies have tremendous strengths in sample size and representativeness and deserve a bright spotlight. We also agree that we could have more fully articulated our perspective, and we are happy to elaborate.

For all their strengths, the WHO and other epidemiological studies have not answered the question “what distinguishes suicide attempters from suicide ideators?” They have identified several strong predictors of ideation, but zero strong predictors of attempts among ideators. In addition, like any other study, WHO did not examine all relevant variables (e.g., hopelessness) and relied on a particular measurement approach (i.e., relatively brief, fully structured measures conducive to large studies). Finally, the WHO studies on suicide are already well reported and well summarized in high-profile outlets (e.g., Nock et al., 2012). For all these reasons, we felt it would be useful to examine whether other studies using diverse measures and methods would yield different or additional findings regarding the attempter–ideator distinction.

Nock et al. (2016) suggest we should have combined these studies and WHO findings into a single meta-analysis. Our concern was that this approach would have muddled rather than clarified any potential differences between WHO and the rest of the literature. Thus, we chose to identify converging findings across the 27 studies we meta-analyzed, and then compare these with WHO in a section titled “Comparisons with the WHO’s World Mental Health Findings.”

We conclude that findings from our meta-analysis and the WHO studies were similar: “demographic factors, psychiatric diagnoses, and life history variables

are much less powerful in distinguishing attempters from ideators than . . . separating those with a history of suicide ideation from those without” (May & Klonsky, 2016, p. 9). We also found that hopelessness fails to distinguish attempters from ideators, which was not addressed by WHO. Nock et al. (2016) note variables examined by WHO that we did not describe (e.g., specific forms of childhood adversities), and express concern that readers are not informed about them. However, we share the conclusion by Glenn and Nock (2014) that the WHO variables explain minimal variability (not more than 7%) in suicide attempts among ideators. Thus, we felt our summary was accurate and sufficient, and opted not to single out variables that offered weak prediction.

POINT 3: RISK FACTORS VERSUS CORRELATES

Nock and colleagues suggest our meta-analysis does not adequately appreciate or acknowledge the difference between correlates and risk factors (prospective predictors). We do not agree with Nock and colleagues’ (2016) portrayal of our work, but we first respond to the point’s substance.

Although we agree fully that longitudinal studies are needed to identify prospective predictors, we believe our meta-analysis of the correlational literature is useful for several reasons. First, correlational studies represent the majority of studies on, and thus knowledge about, suicide. However, as described in our article, the interpretation of these studies is skewed by a design flaw: Most fail to compare suicide attempters to nonattempting ideators, and instead compare attempters to a non-suicidal group. As a result, variables that only relate to ideation can appear to be correlates of attempts. Our meta-analysis corrects this misinterpretation. Second, correlates of suicide attempts are often included in widely disseminated lists of warning signs or risk factors. It is therefore important to make clear that most are actually correlates of ideation, not attempts. Third, even though correlational studies cannot infer causality, they *can* refute causal theories when an expected correlation is absent. Thus, demonstrating the absence of relationships often assumed to exist (e.g., that hopelessness is higher in attempters than ideators) is useful and important. This is a critical point that Nock et al. (2016) do not appear to appreciate. Finally, our meta-

analysis did not include prospective studies because these suffer from the same design limitation—a tendency to predict attempts without accounting for ideation—and there were almost none that met our inclusion criteria. That said, we are enthused by upcoming meta-analyses of prospective studies by Nock, Franklin, and others (see www.vandytaplab.com/metatas).

We also note that Nock and colleagues' (2016) portrayal of our work in Point 3 is inaccurate. They misstate that risk factors for the transition from ideation to action were our "putative focus of interest," even though our focus on correlates is clear in the Introduction: "The aim of this article is to consolidate what is known about common suicide correlates in differentiating adults who have attempted suicide . . . from those who have only considered suicide" (May and Klonsky, 2016, p. 3). Moreover, Nock et al. wrongly suggest our meta-analysis ignored the difference between correlates and risk factors. In actuality, we emphasize the distinction between correlates and risk factors repeatedly, including at the beginning of our Introduction, as well as both the beginning and end of our Discussion.

CONCLUSION

We appreciate the opportunity to reply to Nock et al. (2016). Unfortunately, their inaccurate portrayals of our work distort its content, magnify real and perceived areas of disagreement, and hinder substantive discourse. Nevertheless, we enthusiastically endorse the excellent suggestions for future research offered in their commentary's final section, and hope this exchange helps move the field forward.

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